102. ROUTINE COSTS

2. Other Operating Costs. The costs in this category shall include the supplies, purchased services, salaries, wages and benefits for:

a. Dietary Services

b. Laundry services including the laundering of personal clothing which is the normal wearing apparel in the facility. The cost of dry cleaning personal clothing, even though it is the normal wearing apparel in the facility, is excluded as an allowable cost. Providers shall launder institutional gowns, robes and personal clothing which is the normal wearing apparel in the facility without charge to recipients. The recipient or responsible party may at their discretion make other arrangements for the laundering of personal clothing.

102. ROUTINE COSTS

c. Housekeeping

d. Plant Operation and Maintenance

e. General and Administrative Services

3. Capital Costs. The costs in this category shall include:

a. Depreciation on building and fixtures

b. Depreciation on equipment

c. Capital related interest expense

d. Rent

4. Indirect Ancillary Costs. Indirect ancillary costs are those costs associated with ancillary departments (including fringe benefits) other than those costs listed under Section 103.

103. ANCILLARY SERVICES

A. ANCILLARY SERVICES. Ancillary services are those for which a separate charge is customarily made and are designated for purposes of this payment system as being limited to the following:

Physical Therapy

Occupational Therapy

Speech Therapy

Laboratory procedures

X-ray

Oxygen and other related oxygen supplies. Respiratory therapy (excluding the routine administration of oxygen

Reimbursement for ancillary services shall be made on the basis of reasonable, allowable direct costs of the services, and may be subject to maximum allowable cost limits under Federal regulations.

NOTE: Effective October 1, 1990, drugs for residents in Nursing Facilities shall be reimbursed through the pharmacy program.

TN # 96-10 Approved MAY 16 2001 Eff. Date 7-1-96
Supersedes
TN # 91-19

103. ANCILLARY SERVICES

B. Oxygen concentrator limitations. Effective October 1, 1991, the allowable cost of oxygen concentrator rentals shall be limited as follows:

1. A facility may assign a separate concentrator to any resident who has needed oxygen during the prior or current month and for whom there is a doctor's standing order for oxygen. For the charge by an outside supplier to be considered as an allowable cost, the charge shall be based upon actual usage. A minimum charge by an outside supplier is allowable if this charge does not exceed twenty-five (25) percent of the Medicare Part B maximum. The minimum charge is allowable if the concentrator is used less than an average of two (2) hours per day during the entire month (for example, less than 60 hours during a thirty (30) day month). The maximum allowable charge by the outside supplier shall not exceed one hundred (100) percent of the Medicare Part B maximum. For the maximum charge to a facility to be considered as the allowable cost, the concentrator shall have been used on average for a period of at least eight (8) hours per day for the entire month (for example, 240 hours during a thirty (30) day month). In those cases where the usage exceeds that necessary for the minimum

103. ANCILLARY SERVICES

charge and is less than the usage required for the maximum charge, the reimbursable shall be computed by dividing the hours of usage by 240 and then multiplying the result of this division by the Medicare Part B maximum charge (for example, if a concentrator is used less than 220 hours during a thirty (30) day month and the maximum Part B allowable charge is $250.00; then the allowable charge is computed by dividing the 220 hours by 240 hours and then multiplying the product of this division by $250.00 to obtain the allowable charge of $229.17). Allowable oxygen costs outlined in this paragraph shall be considered to be ancillary costs.

2. A facility shall be limited to one (1) standby oxygen concentrator for each nurses' station. The Medicaid Services Program may grant waivers of this limit. This expense shall be considered as a routine nursing expense for any month in which there is no actual use of the equipment. The allowable cost for standby oxygen concentrators shall be limited to twenty-five (25) percent of the maximum allowable payment under Medicare Part B for in home use.

104. INFLATION FACTOR

The inflation factor index shall be used in the determination of the prospective rate shall be established by the Department for Medicaid Services. The index shall be based on Data Resources, Inc., forecasting.. The index represents an average inflation rate for the year and shall have general applicability to all facilities.

The inflation factor shall be applied to nursing services costs and all other costs excluding capital costs.

BASIC INTERMEDIATE CARE

COST INCENTIVE AND INVESTMENT FACTOR SCHEDULE

BASIC PER DIEM COST	INVESTMENT FACTOR PER DIEM AMOUNT	INCENTIVE FACTOR PER DIEM AMOUNT
$40.99 & Below	$.92	$.58
$41.00 - $41.99	.86	.50
$42.00 - $42.99	.78	.41
$43.00 - $43.99	.70	.32
$44.00 - $44.99	.61	.21
$45.00 - $45.99	.51	.09
$46.00 - Maximum*	.35	-

Maximum Payment Set at 102% of Median

*Total rate cannot exceed maximum

SKILLED NURSING FACILITIES

COST INCENTIVE AND INVESTMENT FACTOR SCHEDULE

BASIC PER DIEM COST	INVESTMENT FACTOR PER DIEM AMOUNT	INCENTIVE FACTOR PER DIEM AMOUNT
$59.99 & Below	$.92	$.58
$60.00 - $61.99	.86	.50
$62.00 - $63.99	.78	.41
$64.00 - $65.99	.70	.32
$66.00 - $67.99	.61	.21
$68.00 - $69.99	.51	.09
$70.00 - Maximum*	.35	-

Maximum Payment Set at 102% of Median of Freestanding Facilities**

* Total rate cannot exceed maximum

** Maximum for hospital based facilities is 125% of the maximum for freestanding facilities.

106. COST SAVINGS INCENTIVE FACTOR

For the dual purpose of providing an incentive for cost containment as well as compensation for business risk and a reasonable return on investment, a Cost Savings Incentive Factor (CSI) as determined by the Department for Medicaid Services shall be applied to prospective current year per diem cost in determination of a final prospective rate for each facility.

COST SAVINGS INCENTIVE. Providers shall be eligible for a Cost Savings Incentive (CSI) Factor if the facility rate is not in excess of 110 percent of the median of the appropriate cost array. CSI payments shall be computed on both the Nursing Services and All Other cost centers., It shall be ten (10) percent of the difference between the facility's per diem cost and the upper limit from the appropriate array. The CSI shall be limited to no more than one (1) dollar and fifty (50) cents per diem for each of the two cost categories.

107. UPPER LIMITS

To prevent unlimited cost increases, the Department for Medicaid Services shall establish upper limits for reimbursement of Nursing Services costs and All Other costs. Upper limits are designed to reflect what is reasonable and adequate to meet the cost which must be incurred by efficient and economically operated facilities.

For purposes of setting upper limits the NFs shall be divided into urban and rural arrays. The urban array shall include all freestanding facilities (excluding MRS, IMD, and Pediatric) within a Standard Metropolitan Area (SMA). The rural array shall include all freestanding facilities (excluding MRS, IMD, and Pediatric) in non-SMA counties.

A. NURSING SERVICE COSTS. The upper limit for Nursing Services costs shall be set at 115 percent of the median of the urban or rural array, as appropriate, of the Nursing Services cost per case mix unit. The cost per case mix unit is derived by dividing the nursing cost per day (trended and indexed for inflation) by the average value of the nursing assessments for the facility.

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Supersedes
TN # 90-6

107. UPPER LIMITS

B. ALL OTHER COSTS. The upper limit for All Other costs shall be set at 115 percent of the median of the urban or rural array, as appropriate, of the All Other cost per day (trended and indexed for inflation).

C. HOSPITAL-BASED NURSING FACILITIES. The upper limits for each cost area for hospital-based nursing facilities shall be set at 125 percent of the appropriate upper limit for freestanding facilities as defined above. Hospital-based nursing facilities shall be defined as those nursing facilities which are in the same building or are attached to an acute care hospital and share common administration, nursing staff and ancillary services with the hospital; however, those facilities classified as hospital-based skilled nursing facilities on June 30, 1989 shall remain classified as hospital-based nursing facilities.

D. NEW FACILITIES. New facilities which have an interim rate established subject to cost settlement shall not be included in the arrays for purposes of determining the upper limits; however, these facilities are subject to the upper limits.

107. UPPER LIMITS

E. COST REPORTS UTILIZED. Upper limits shall be established on the basis of the most current cost report available as of May 16 of each year. If a desk review or audit of the most current cost report is completed after May 16 but prior to universal rate setting for the year, the desk reviewed or audited data shall be utilized for rate setting. Should unaudited data be utilized, rates shall be adjusted when the report is audited, i.e., if a change of ownership has occurred and a new owner's cost report of at least six (6) months duration is available as of May 16, this data shall be utilized. If this six (6) month cost report is not available, then the cost report of the previous owner shall be utilized in accordance with the timeframes set forth in this paragraph.

physician as a medical necessity), Cleansing Agents (Alcohol sponges), Colostomy Supplies, Dressings (telfa, ABD pads, gauze squares, tape, bandages), Food Supplements and supplies related to their administration (Compleat-B, Ensure, Flexical, Isocal, Meritene, Sustacal, Vital, Vivonex), Intravenous Supplies, Levine Tube, Liniments (Ben-Gay, Deep Heat Rub, Icy Hot), Miscellaneous supplies (Disposable Gloves, Q-Tips, Swabs, Isolation gowns), Naso-Gastric tube, Protection Items (Perineal pads) Sanitary/Personal items (sanitary napkins, feminine hygiene deodorant sprays, toothbrushes, toothpaste, razors, all types of deodorants, mouthwash), Skin Lubricant, Lotions & Creams (Jergens Lotion, Keri-Lotion, Aveeno Lotion, A & D Hand Cream, Corn Starch, Glycerine, Vaseline).

Irrigation supplies and solutions are considered ancillary services if they are legend or non-legend drugs and/or if they are utilized with indwelling urethral catheters.

Hyperalimentation as a drug cost includes the hyperalimentation solution, subclavian catheter (Hickman Catheter, etc.), heparinization solution, tubing filter, sterile tubing, antimicrobial solution, povidone-iodine ointment (or substitute), and cellulose membrane filter. Other items and services are considered ancillary or routine as presently defined.

Reimbursement for ancillary services will be made on the basis of reasonable, allowable direct costs of the services, with two exceptions;

108. HOLD HARMLESS

In order to assure a smooth transition to the Case Mix Assessment Reimbursement System (CMAR), nursing facilities shall be entitled to a hold harmless amount for the period from October 1, 1990 through June 30, 1992. The hold harmless amount is the amount, if any, by which the July 1, 1990 allowable (subject to audit adjustment) facility rate plus an adjustment for ancillary costs being shifted to routine costs (less a nurse aide training per diem allowance of one (1) dollar and twenty (20) cents exceeds the allowable facility rate as computed on October 1, 1990 (subject to audit adjustment) and July 1, 1991, excluding the revised nurse aide training per diem allowance under the CMAR system. For July 1, 1991 rate purposes, the July 1, 1990 rate shall be increased by an inflation allowance using the appropriate Data Resources, Incorporated index for inflation. The hold harmless provision shall not be applicable for dual licensed or swing beds.

109. PROSPECTIVE RATE COMPUTATION

Prospective rates are established annually for a universal rate year, July 1 through June 30. Rate setting shall be based on the most recent cost reports available by May 16. If a desk review or audit of the most recent cost report is completed after May 16 but prior to universal rate setting for the rate year, the desk reviewed or audited data shall be utilized for rate setting. If a facility's rate is based upon a report which has not been audited or desk reviewed, the facility's rate is subject to revision after the cost report has been audited or desk reviewed.

A. Allowable routine Nursing Facility cost is divided into two components: Nursing Services Cost and All Other Costs. These components are defined as Section 102.

B. Allowable cost for the Nursing Services Cost component shall be trended to the beginning of the universal rate year and indexed for the period covering the rate year based on an inflation factor obtained from the Data Resources, Incorporated (DRI) forecast table for Skilled Nursing Facilities.

C. Allowable cost for the All Other Cost center, with the exception of the Capital Cost subcomponent, shall be trended and indexed in the same manner as Nursing Services costs.

109. PROSPECTIVE RATE COMPUTATION

D. The total Nursing Facility Cost for each cost category, after trending and indexing, shall be divided by total Certified Nursing Facility days in order to compute a per diem. A minimum occupancy limit of ninety(90) percentof certified bed days available, or actual bed days used if greater, and a maximum occupancy limit of ninety-eight (98) computed in the same manner, shall be used in computing the per diem.

E. The Nursing Services Cost per diem shall be converted to a nursing cost per case mix unit by dividing the per diem by the facility's average case mix weight.

1. The average case mix weight utilized for the initial rate setting on October 1, 1990 shall be based on the Case Mix Assessments performed by the Peer Review Organization PRO contractor during the period of July and August 1990.

2. The average case mix weight utilized for the annual July 1 rate setting on or after July 1, 1991, shall be an average of all quarterly Case Mix Weights for any assessment quarter for which any portion of that quarter falls within the period covered by the facility's Cost Reporting period which is used in that rate setting. If the cost reporting period used to set the July 1, 1991 does not correspond

with any assessment quarter, the average case mix weight for the July through August 1990 assessment period shall be utilized.

F. The cost per case mix unit shall be arrayed in two (2) arrays. One (1) array shall be for the Urban Nursing Facilities and a second array shall be for the Rural Nursing Facilities. The maximum allowable cost in each array shall be set at 115 percent of the median cost in that array.

G. The "Adjusted Nursing Services Cost Per Diem" shall be determined by multiplying the lesser of the facility's actual cost per case mix unit or the maximum allowable cost per case mix unit times the average case mix weight from the most recent assessment.

H. The facility's latest average case mix weight shall be multiplied times the "maximum allowable cost per case mix unit" to determine the facility's "maximum allowable adjusted case mix per diem."

I. If the facility's cost per case mix unit is equal to or less than 110 percent of the median cost per case mix unit in the facility's array, then the facility shall receive a "Cost Savings Incentive Per Diem for Nursing Services"

equal to 10 percent of the difference between the facility's "Adjusted Nursing Services Cost Per Diem" and the facility's "maximum allowable adjusted Case Mix Per Diem" not to exceed one (1) dollar and fifty (50) cents per day.

J. The facility's "Adjusted Nursing Services Cost Per Diem" shall be added to the facility's "Cost Savings Incentive Per Diem for Nursing Services" to determine the facility's "Nursing Services Per Diem Payment Rate."

K. On a quarterly basis for quarters beginning October 1, January 1, and April 1 the steps outlined in 109G through 109J shall be repeated to compute a revised "Nursing Services Per Diem Payment Rate" for that quarter.

L. For the annual rate setting effective July 1, the "All Other Costs Per Diems," as computed based on Section 109D, shall be separately arrayed for Urban and Rural facilities. The "Maximum All Other Cost Per Diem" shall be equal to 115 percent of the median "All Other Cost Per Diem" in the applicable array.

M. The facility's "Allowable All Other Cost Per Diem" shall be the lesser of the facility's "All Other Cost Per Diem" or the "Maximum All Other Cost Per Diem" for the applicable array.

N. If the facility's "All Other Cost Per Diem" is equal to or less than 110 percent of the median "All Other Cost Per Diem" for the applicable array, then the facility shall receive an "All Other Cost Savings Incentive Per Diem" which shall be equal to 10 percent of the difference between the facility's "All Other Cost Per Diem" and the "Maximum All Other Cost Per Diem" for the applicable array. This Cost Savings Incentive shall not exceed one (1) dollar and fifty (50) cents per day.

O. The facility's "All Other Per Diem Payment Rate" shall be equal to the total of the "Allowable All Other Cost Per Diem" and the "All Other Cost Savings Incentive Per Diem."

P. Add-on Per Diems of one (1) dollar and thirty-eight (38) cents to cover universal precautions cost, thirty-eight (38) cents to cover indirect nurse aide training costs attributable to replacement of nurse aides in training or testing status, and four (4) cents to cover medical director costs shall be included in the facility's rate through June 30, 1991.

109. PROSPECTIVE RATE COMPUTATION

Q. The facility's "Computed Rate" shall be equal to the total of the "Nursing Services Per Diem Payment Rate," "All Other Per Diem Payment Rate," applicable add-on per diems and any adjustments computed under Section 110 or 111 which were not included in the arrayed cost for Nursing Services or All Other Cost.

R. If applicable, a "hold harmless" add-on amount computed under Section 108 shall be added to the computed rate.

110. ADJUSTMENT TO PROSPECTIVE RATE

A. Upon request by participating facility, an increase in the prospective rate (subject to the upper limits) shall be considered if the cost increase is attributable to one (1) of the following reasons:

1. Governmentally imposed minimum wage increases, unless the minimum wage increase was taken into account and reflected in the setting of the trending and index factor;

2. Direct effect of newly published licensure requirements or new interpretations of existing requirements by the appropriate governmental agency as issued in regulation or written policy material which affects all facilities within the class. The provider shall demonstrate through proper documentation that a cost increase is the result of a new policy interpretation; or

3. Other direct governmental actions that result in an unforeseen cost increase (for OBRA 1987 see Section 111).

110. ADJUSTMENT TO PROSPECTIVE RATE

To receive a rate increase (except for Federal or State minimum wage increases), it shall be demonstrated by the facility that the amount of cost increase resulting directly from the governmental action exceeds on an annualized basis, the inflation factor allowance included in the prospective rate for the general cost area in which the increase occurs. For purposes of this determination, costs shall be classified into two (2) general categories, Nursing Service and All Other Cost. Within each of these two (2) categories, costs are to be further broken down into "salaries and wages" and "other costs." Those costs directly related to salaries and fringe benefits shall be considered as "salaries and wages" when determining classifications.

Other unavoidable cost increases of a substantial nature which can be attributed to a single unique causal factor shall be evaluated with respect to allowing an interim rate change. Ordinarily budget items such as food, utilities, and interest where cost increases may occur in a generalized manner shall be excluded from this special consideration. Secondary or indirect effects of governmentally imposed cost increases shall not be considered as "other unavoidable cost increases."

110. ADJUSTMENT TO PROSPECTIVE RATE

The increase in the prospective rate shall be limited to the amount of the increase directly attributable to the governmental action to the extent that the increase on an annualized basis exceeds the inflation factor allowance included in the prospective rate for the cost center in question. In regard to minimum wage increases, the direct effect shall be defined as the time worked by total facility employees times the dollar amount of change in the minimum wage law. However, the amount allowed shall not exceed the actual salary and wage increase incurred by the facility in the month the minimum wage increase is effective. An exception to this shall be considered when there is an unusual occurrence which causes a decrease in the normal staff attendance in the months the minimum wage increase is effective.

The effective date of a prospective rate adjustment shall be the first day of the calendar month in which the direct governmental action occurred. To be allowable, a request for an adjustment to the prospective rate shall be received by the Department for Medicaid Services within sixty (60) days of the direct governmental action, except where the costs are to be accumulated.

110. ADJUSTMENT TO PROSPECTIVE RATE

If two (2) or more allowable reasons for a rate change occur in the same facility fiscal year, the costs may be accumulated and submitted at one (1) time. Each cost shall be documented. A rate adjustment, if allowed, shall be effective the first day of the calendar month in which the latest direct governmental action occurred if the request is made within the required sixty (60) days.

110A. RATE ADJUSTMENT FOR PROVIDER TAX

110A. RATE ADJUSTMENT FOR PROVIDER TAX

To take into account the cost of the provider tax effective July 1, 1993, the Department for Medicaid Services shall pay an add-on amount to each facility's rate effective August 1, 1993 based on the submission of an interim rate increase request (Schedule J-Tax). The portion of the taxes paid for the month of July 1993 which pertain to the Medicaid certified beds in the facility shall be used to compute an add-on to the facility's rate effective August 1, 1993. The information contained on the interim rate request shall correspond to the information contained in the Provider Tax forms filed for the month of July, 1993. Facilities shall submit a Schedule J-Tax for each month through December 1993 (January submission to the Revenue Cabinet) along with the supporting Revenue Cabinet schedules. Schedule J-Tax forms shall be submitted by providers by the end of the month in which the corresponding filing with the Revenue Cabinet is made. The Department for Medicaid Services shall reconcile the tax add-on based on Schedule J-Tax forms filed subsequent to the August 1993 filing.

111. OTHER OBRA NURSING HOME REFORM COSTS

111. OTHER OBRA NURSING HOME REFORM COSTS

Effective October 1, 1990 and thereafter, facilities shall be required to request preauthorization for costs that must be incurred to meet OBRA 87 Nursing Home Reform costs in order to be reimbursed for such costs. The preauthorization shall show the specific reform action that is involved and appropriate documentation of necessity and reasonableness of cost. Upon authorization by the Department for Medicaid Services, the cost may be incurred. A request for a payment rate adjustment may then be submitted to the Department for Medicaid Services with documentation of actual cost incurred. The allowable additional amount shall be added on to the facility's rate (effective with the date the additional cost was incurred) without regard to upper limits or the Cost Savings Incentive [CSI] factor (i.e., the authorized Nursing Home Reform cost shall be passed through at 100 percent of reasonable and allowable costs) through June 30, 1991. For purposes of the July 1, 1991 rate setting, amounts associated with OBRA rate adjustments received prior to May 15, 1991 shall be folded into the applicable category of routine cost (subject to upper limits). Preauthorization shall not be required for nursing home reform costs incurred during the period July 1, 1990, through September 30, 1990; however, the actual costs incurred shall be subject to tests of reasonableness and necessity and shall be fully documented at the time of the request

111. OTHER OBRA NURSING HOME REFORM COSTS

for rate adjustment. Facilities may request multiple preauthorizations and rate adjustments (add-ons) as necessary for implementation of nursing home reform. Facility costs incurred prior to July 1, 1990, shall not (except for the costs previously recognized in a special manner, i.e., the universal precautions add-on and the nurse aid training add-on) be recognized as being nursing home reform costs. The special nursing home reform rate adjustments shall be requested using forms and methods specified by the Department for Medicaid Services. A nursing home rate adjustment shall be included within the cost base for the facility in the rate year following the rate year for which the adjustment was allowed. Interim rate adjustments for nursing home reforms shall not be allowed for period after June 30, 1993. For purposes of the July 1, 1992 and July 1, 1993 rate setting, all amounts associated with OBRA rate adjustments for the preceding rate year shall be folded into the applicable category of routine cost (subject to upper limits). All nursing home reform rate adjustment requests shall be submitted by September 30, 1993.

BED SIZE	MAXIMUM COMPENSATION
0 - 50	$31,300
51 - 99	36,000
100 - 149	40,200
150 - 199	48,000
200+	49,200

These compensation maximums shall be increased on July 1 of each year by the Inflation Factor index for wages and salaries (Data Resources, Inc.).

111 A. ADMINISTRATORS COMPENSATION:

The reasonable cost of full-time nonowner administrators may be included as an allowable cost so long as it does not exceed the applicable compensation limit for an administrator.

Fringe benefits routinely provided to all employees and the administrator will not be considered a part of compensation.

Reasonableness of compensation for an administrator will be based on total licensed beds (all levels) in accordance with the following schedule. The amount attributable to each level of care will be determined utilizing the step-down method of cost allocation.

BED SIZE	MAXIMUM COMPENSATION
0-50	$41,400
51-99	46,800
100-149	52,400
150-199	62,600
200+	64,000

These compensation maximums shall be increased on July 1 of each year by the Inflation Factor index for wages and salaries (Data Resources, Inc.).